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Sixty-seventh session
Agenda item 34
Protracted conflicts in the GUAM area and their implications for international peace, security and development

Security Council
Sixty-eighth year

Identical letters dated 2 April 2013 from the Chargé d'affaires a.i. of the Permanent Mission of Georgia to the United Nations addressed to the Secretary-General and the President of the Security Council

I have the honour to transmit herewith a statement of the Ministry of Foreign Affairs of Georgia, dated 29 March 2013, regarding the twenty-third round of the Geneva international discussions (see annex).

I should be grateful if you would circulate the present letter and its annex as a document of the sixty-seventh session of the General Assembly under agenda item 34, entitled "Protracted conflicts in the GUAM area and their implications for international peace, security and development", and of the Security Council in accordance with rule 6 of the provisional rules of procedure of the Council.

(*Signed*) Vakhtang **Makharoblishvili**
Minister Extraordinary and Plenipotentiary
Chargé d'affaires a.i. of Georgia to the United Nations

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Annex to the identical letters dated 2 April 2013 from the Chargé d'affaires a.i. of the Permanent Mission of Georgia to the United Nations addressed to the Secretary-General and the President of the Security Council

Statement of the Ministry of Foreign Affairs of Georgia regarding the twenty-third round of the Geneva international discussions

The twenty-third round of the Geneva international discussions was held on 27 March 2013. The participants in the discussions took part, in an individual capacity, in the two working groups: Working Group I, which focused on security and stability in Georgia's occupied Abkhazia and the Tskhinvali region, and Working Group II, which focused on the issues related to the safe and dignified return of internally displaced persons and refugees to the places of their original residence. The discussions were co-chaired by representatives of the United Nations, the European Union and the Organization for Security and Cooperation in Europe and attended by the participants from Georgia, the Russian Federation and the United States of America. The Head of the Provisional Administration of the former South Ossetian Autonomous District and the representatives of the Sokhumi and Tskhinvali proxy regimes also took part in the twenty-third round of the discussions.

The head of the Georgian team reiterated the commitment of the new negotiating team to the Geneva international discussions as the key format for the implementation of the ceasefire agreement of 12 August 2008.

On 26 March, an information session was held on the role of women in conflict resolution. The invited experts provided the participants with information about the international political and legal framework for ensuring women's full, equal and effective participation at all stages of peace processes and contributing to strengthening their role in peace and security.

In the framework of Working Group I, the participants addressed one of the central items of the agenda: the non-use of force. The group of experts that had been established at the twenty-first round asked the co-Chairs about the reasoning behind the consolidated text of the draft statement of the participants in the Geneva international discussions on the non-use of force, which had been revised by the co-Chairs to accommodate the differing views expressed during previous drafting sessions. The experts agreed to exchange views and opinions regarding the text without engaging in drafting at that stage. The discussions showed that the divergences with regard to principled positions remained unchanged. The participants agreed to engage in the drafting of the document circulated by the co-Chairs at the next round.

The Georgian participants stressed once again that the statement could only be issued after the Russian side had reciprocated Georgia's unilateral, legally binding pledge on the non-use of force, which had been made in 2010 and had recently been reiterated and supported by the Parliament of Georgia. Georgia once again called upon the Russian Federation to fulfil its outstanding obligation.

In Working Group I, the participants also discussed the security situation on the ground. Georgia raised concerns about the recent intensification of the so-called

"borderization" process along the occupation line in the Tskhinvali region, which was affecting the villages of Tamarasheni-Dvani, Atotsi, Didi Khurvaleti and Gugutiantkari. The Georgian side emphasized the necessity of ensuring that the European Union Monitoring Mission in Georgia had access to both regions so that it could fully implement its mandate in Georgia. Georgia also raised concerns about the continued obstruction of the Gali Incident Prevention and Response Mechanism, and stressed the importance of its resumption in its full composition and without preconditions. In Working Group I, the participants from Georgia once again stressed the need to create valid and functional international security arrangements.

In Working Group II, the Georgian participants underlined the need to address the concrete concerns of the conflict-affected population and provide practical solutions to tangible humanitarian and human rights issues. Georgia expressed particular concern about the imposition of severe restrictions on the freedom of movement, which affects the everyday life of people residing within and in the vicinity of the occupied regions, in particular with regard to their right to education, access to health care and other social and economic rights. The participants from Georgia stressed the responsibility that the Russian Federation bears for violations of these fundamental human rights. The Georgian side expressed its readiness to actively engage in substantive dialogue on specific aspects from the catalogue on best practices and freedom of movement presented by the co-Chairs at the twenty-second round. As a first step towards providing for the progressive realization of the freedom of movement in a non-political manner, on the basis of the principles of transparency and predictability, Georgia confirmed its support for the principles and modalities presented by the Office of the United Nations High Commissioner for Refugees for facilitating interaction between the divided communities by organizing humanitarian visits.

The twenty-fourth round of the Geneva international discussions will be held on 25 and 26 June 2013.

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General Assembly

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Sixty-seventh session
Agenda item 11
Implementation of the Declaration of Commitment on HIV/AIDS and the Political Declarations on HIV and AIDS

Accelerating the AIDS response: achieving the targets of the 2011 Political Declaration

Report of the Secretary-General

Summary

An unprecedented opportunity exists to lay the groundwork for the eventual end of the AIDS epidemic. Extraordinary scientific breakthroughs, concerted global action and bold progress by individual countries have set the world on course to bring the AIDS epidemic completely under control. Indeed, significant progress has been made towards achieving the ambitious targets of the Political Declaration on HIV and AIDS: Intensifying our Efforts to Eliminate HIV and AIDS, adopted in 2011 by the General Assembly.

The numbers of new HIV infections and of AIDS-related deaths continue to decline globally because life-saving prevention and treatment services are reaching more people than ever. In 25 low-income and middle-income countries, the rate of new HIV infections has been reduced by more than half, including in sub-Saharan Africa, the region most affected by HIV. Most significantly, half of the global reductions in new infections in the past two years have been among newborns, paving the way for an AIDS-free generation.

In the 24 months to December 2011, the number of people with access to treatment increased by 63 per cent globally. In addition, there were more than half a million fewer AIDS-related deaths in 2011 than in 2005.

The largest reductions in AIDS-related deaths are taking place in countries where HIV has the strongest grip. In 2011, South Africa had 100,000 fewer deaths than in 2005, Zimbabwe nearly 90,000 fewer, Kenya 71,000 and Ethiopia 60,000. In sub-Saharan Africa, the number of AIDS-related deaths has fallen by one third in the past six years, with the number of people receiving antiretroviral treatment increasing by 59 per cent in the past two years alone.

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Low-income and middle-income countries have invested an unprecedented proportion of their own domestic resources in the AIDS response. African leaders have used AIDS as an entry point to enhance their leadership and ownership of the international agenda for health and development. Asian ministers have united to address the HIV-related needs of women and girls.

While the progress of the global AIDS response is impressive, the AIDS epidemic is far from over. AIDS remains the leading cause of death among women between 15 and 49 years of age worldwide. It is the leading cause of life years lost in Southern and Eastern Africa, the third leading cause of death in Eastern Europe and the sixth leading cause of death worldwide. As at December 2011, more than 17 million children had lost one or both parents to AIDS.

To build on recent gains, and to tackle the devastating human and developmental challenges still posed by the epidemic, the international community must fulfil the commitments of the 2011 Political Declaration on HIV and AIDS, which requires proactively revising and adapting approaches to seize new opportunities as they emerge. To bring the AIDS epidemic completely under control, the concept of shared responsibility and global solidarity must be advanced. Investment in the AIDS response by low-income and middle-income countries and by international donors must continue to grow to close the funding gap. HIV programmes must become more strategic and focus investment on interventions that have the greatest impact and that meet the needs of the populations most in need. Synergies between HIV programmes and broader development initiatives, such as social protection programmes, must be maximized to address the social, legal and economic conditions that increase vulnerability to HIV.

I. Introduction

1. The Political Declaration on HIV and AIDS: Intensifying our Efforts to Eliminate HIV and AIDS, adopted in 2011, renewed global solidarity and established a set of 10 specific and time-bound targets to be met by 2015.

2. The present report provides a description of progress to date in meeting those targets. It draws primarily on comprehensive reports on national progress in the AIDS response submitted by 186 countries in 2012. With 96 per cent of the 193 States Members of the United Nations reporting in 2012, the global AIDS response progress reporting system has among the highest response rates of any international health and development monitoring mechanism — a vivid reflection of the breadth and depth of global commitment to the AIDS response. While focusing on achievements in the global AIDS response, the present report is also intended to inform and strengthen the broader development agenda, including the special event of the General Assembly to follow up on efforts made towards achieving the Millennium Development Goals, to be held in September 2013.

3. Member States continue to face considerable challenges in their efforts to tackle HIV. Some 7 million eligible people lack access to life-saving HIV treatment, with access lowest among children. New HIV infections are continuing to rise in Eastern Europe and Central Asia, as well as in the Middle East and North Africa. Women and girls continue to be disproportionately affected and key populations that have the highest HIV prevalence lack equitable access to services. In addition, legal and policy barriers continue to undermine effective responses to the epidemic in many parts of the world. Persistent global economic challenges impede efforts to mobilize essential investment to close the funding gap in the global response to the AIDS epidemic, while the widening economic gap between the rich and the poor throughout the world undermines efforts to mount an inclusive, optimally effective response.

4. Although these challenges are real, overcoming them is possible. The history of the AIDS response has consistently demonstrated that global solidarity, evidence-based action and the active involvement of the people most affected by the epidemic can overcome barriers to progress. Tackling the challenges also requires swiftly scaling up programmes that deliver the greatest impact, putting sound policy frameworks in place that optimize programme effectiveness and promoting synergies between HIV and other development initiatives.

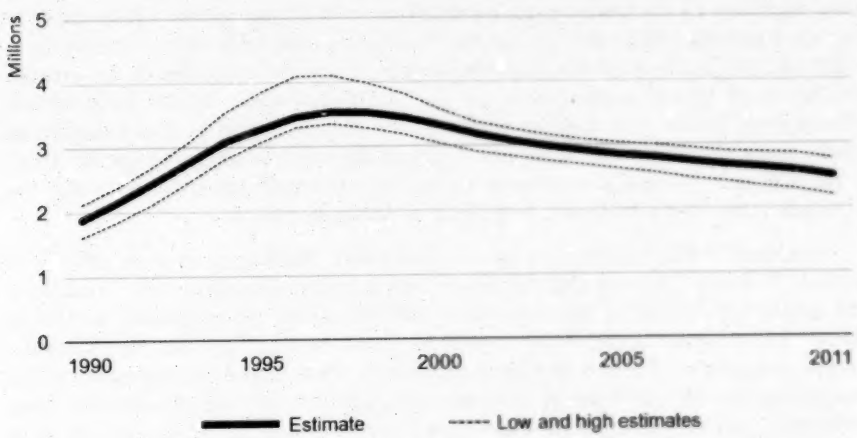
II. Status of the epidemic

5. Globally, an estimated 34 million (31.4 million-35.9 million) people were living with HIV at the end of 2011. Sub-Saharan Africa, with nearly 1 in 20 adults living with HIV, remains the region most heavily affected by the epidemic, accounting for 69 per cent of all infections worldwide. Outside sub-Saharan Africa, the Caribbean and Eastern Europe and Central Asia have the highest adult HIV prevalence (1 per cent). National and subnational epidemics are often complex, rapidly evolving and multi-faceted, and epidemiological patterns frequently differ substantially between and within countries.

6. An estimated 2.5 million (2.2 million-2.8 million) adults and children were newly infected with HIV in 2011, 20 per cent lower than in 2001 (see figure I).

Significant declines occurred in the most affected regions: the Caribbean (42 per cent) and sub-Saharan Africa (25 per cent). The decline has been especially sharp among children in recent years, with some 330,000 (280,000-390,000) children newly infected in 2011, 24 per cent lower than the 430,000 (370,000-490,000) infected in 2009.

Figure I
Number of people newly infected with HIV globally, 1990-2011



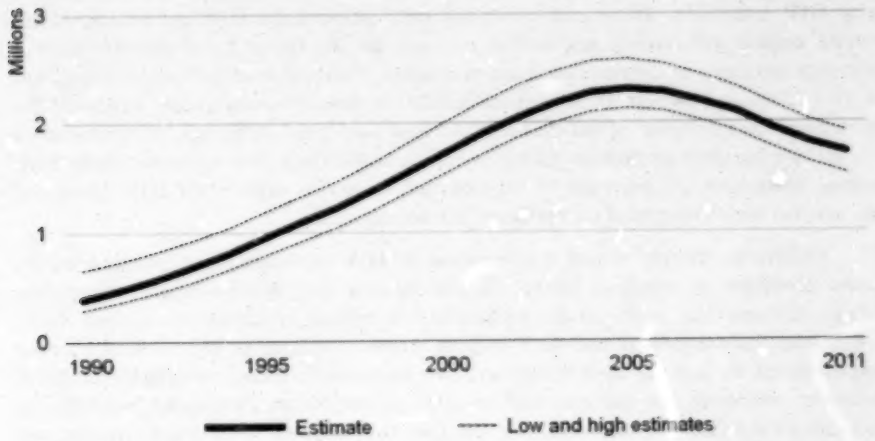
Source: Joint United Nations Programme on HIV/AIDS (UNAIDS).

7. Trends in new HIV infections are not uniformly positive in all parts of the world, with new infections on the rise in Eastern Europe and Central Asia and in the Middle East and North Africa. In addition, while many countries in Asia have successfully reduced new HIV infections, that is not true of the entire region, with infections increasing in some countries.

8. Access to HIV treatment has expanded dramatically, reaching more than 8 million people in low-income and middle-income countries in 2011, or 54 per cent of all those eligible under current treatment guidelines. Treatment coverage is considerably higher in some regions, such as Latin America (68 per cent), the Caribbean (67 per cent), Oceania (69 per cent) and sub-Saharan Africa (56 per cent), than in Eastern Europe and Central Asia (25 per cent) and the Middle East and North Africa (15 per cent).

9. In 2011, 1.7 million (1.5 million-1.9 million) people died from AIDS-related causes, showing a 24 per cent decline from 2005 (see figure II). AIDS-related mortality has, however, increased in several regions, including Eastern Europe and Central Asia (21 per cent) and the Middle East and North Africa (17 per cent). Since 2004, tuberculosis-related deaths among people living with HIV have fallen by 25 per cent globally and by 28 per cent in sub-Saharan Africa.

Figure II
Adult and child deaths as a result of AIDS, 1990-2011



Source: UNAIDS.

10. Young people between 15 and 24 years of age account for 14 per cent of all people living with HIV and 34 per cent of new infections. HIV prevalence among young people has fallen by over 50 per cent since the mid-1990s in the Caribbean and in Eastern Africa, yet the global decline has been approximately 13 per cent.

11. In 2011, women accounted for 49 per cent of all adults living with HIV worldwide. In two regions, more than half of adults living with HIV are women: sub-Saharan Africa (58 per cent) and the Caribbean (52 per cent). In other regions, the percentage of women among adults living with HIV ranges from 25 per cent (Western and Central Europe and North America) to 34 per cent (Asia and the Pacific). Globally, one young woman is newly infected every minute, while young women in sub-Saharan Africa are more than twice as likely as young men their own age to be living with HIV.

12. The impact of the epidemic is substantially greater in some populations. According to surveys, female sex workers are on average 13.5 times more likely than other women to be living with HIV. Prevalence is 22 times higher among people who inject drugs than among the population as a whole. Among men who have sex with men, prevalence is 19 times higher.

III. Key targets for 2015: progress to date and challenges to overcome

13. The present section provides a description of progress to date towards achieving the targets set forth in the 2011 Political Declaration on HIV and AIDS. The 10 targets are part of the global community's broader commitment to ensuring universal access to prevention, treatment, care and support by 2015.

A. Reduce sexual transmission by 50 per cent

14. In many countries, changes in sexual behaviour are associated with declines in new HIV infections. In several countries with generalized HIV epidemics, fewer young people are having sex before the age of 15, fewer have multiple sexual partners and rates of condom use have increased. Favourable trends are not apparent in all countries, however. Risky sexual behaviour among young people is reportedly increasing in a number of sub-Saharan African countries. Although comprehensive sexuality education empowers young people to make informed decisions about their sexual behaviour, 20 per cent of high-burden countries report that HIV education has not yet been integrated into primary school curricula.

15. Efforts to prevent sexual transmission of HIV continue to be undermined by acute problems in condom access in low-income and middle-income countries, where demand has risen to an estimated 10 billion condoms each year. Only 3.4 billion male condoms and 43.3 million female condoms were procured by nine international donors for distribution in low- and middle-income countries in 2011, however. As most low-income and middle-income countries depend on external support for condom procurement, it is unlikely that national investment covered this gap in 2011.

16. Progress in scaling up voluntary medical male circumcision remains slow, although the pace has accelerated in several countries (see table 1). In six countries with high HIV prevalence and low prevalence of male circumcision, less than 5 per cent of the target number of men had been circumcised by the end of 2011. Some countries, such as Botswana, Kenya, Namibia and Swaziland, have accorded priority to programming and increased expenditure in relation to voluntary medical male circumcision.

Table 1
Percentage of the 2015 national targets on male circumcision met by 2011

Less than 5 per cent	*Between 5 and 20 per cent*	*More than 20 per cent*
Malawi	Botswana	Ethiopia
Mozambique	South Africa	Kenya
Namibia	United Republic of Tanzania	Swaziland
Rwanda	Zambia	
Uganda		
Zimbabwe		

Source: UNAIDS.

17. Although 73 per cent of countries reported having implemented HIV prevention programmes for sex workers, surveys in 58 capitals indicate that only 56 per cent of sex workers are reached by prevention services.

18. HIV prevention programmes for men who have sex with men remain inadequate, with coverage of 55 per cent. Condom use also remains low. Most men

who have sex with men surveyed in 69 countries said that they used a condom during their most recent episode of sexual intercourse, but in 56 of those countries fewer than 75 per cent did so.

19. Currently, programmes to reach sex workers and men who have sex with men account for less than 4 per cent of expenditure on basic programmes. UNAIDS advises that the share of expenditure allocated to those populations, in countries where most applicable, should rise to 7 per cent by 2015 in order to maximize impact.

20. Those and other challenges notwithstanding, progress has been made towards the goal of reducing sexual transmission of HIV by 50 per cent by 2015. In 2012 and early in 2013, strong evidence emerged from South Africa and China of the benefits of HIV treatment in terms of prevention at the population level. In rural KwaZulu-Natal in South Africa, uninfected individuals living in a community with high rates of treatment (30-40 per cent of all infected individuals receiving treatment) were 38 per cent less likely to acquire HIV than their peers living in a community where treatment coverage was low (less than 10 per cent of all infected individuals receiving treatment). Among serodiscordant couples (couples in which one partner is HIV-positive and the other is HIV-negative) in China, rates of transmission were 26 per cent lower among couples in which the HIV-positive partner had received treatment compared to couples in which the HIV-positive partner was not receiving treatment. Capturing the full prevention potential of treatment will require improving testing programmes, linking those who test positive to continuing health care, initiating treatment at the right time and ensuring patient retention in clinical settings. Major clinical trials are currently under way to address some of the questions surrounding treatment as prevention, including when to initiate therapy, optimal regimens to reduce the risk of transmission and how best to focus treatment programmes to maximize their impact on preventing HIV transmission.

21. Social support programmes that tackle the economic vulnerability of children and young people have been shown to reduce new HIV infections. An increasing number of countries are pursuing such programmes. In 2012, a large-scale national programme in Kenya found that an unconditional cash transfer to very poor households and households with vulnerable children reduced early sexual debut by 30 per cent and also reduced instances of unprotected sex.

22. New HIV prevention tools are on the horizon. Research into pre-exposure antiretroviral prophylaxis in North America, Latin America, sub-Saharan Africa and Asia and the Pacific has found that it is efficacious when used correctly, offering new hope for female-controlled HIV prevention.

23. Reaching the goal of reducing sexual transmission of HIV by half requires strategic combinations of biomedical, behavioural and structural approaches matched carefully to national and local needs. These programmatic combinations must be supported by concerted efforts to promote gender equality, remove punitive legal frameworks, eliminate stigma and discrimination, protect human rights and enhance social protection. Six major clinical trials are under way on five continents to evaluate various prevention packages that combine multiple interventions to determine what works best to prevent new infections and improve health outcomes for people living with HIV.

B. Reduce HIV transmission among people who inject drugs by 50 per cent

24. How to prevent HIV transmission among people who inject drugs has been known for years. Harm reduction is a well-defined, evidence-based approach of essential interventions, including access to sterile needles and syringes, opioid substitution therapy, counselling and testing, HIV treatment and other health services tailored to the needs of people who inject drugs. Countries that have implemented harm reduction programmes at a sufficient scale have seen sharp reductions in HIV incidence associated with drug use, with some, such as Australia and the United Kingdom of Great Britain and Northern Ireland, approaching the elimination of drug-related HIV transmission.

25. Although some countries have taken steps in recent years to expand access to harm reduction programmes, service coverage remains grossly inadequate. In 2010, only two needle syringes were distributed monthly for every person who injected drugs. It is estimated that sterile syringes are used in only 5 per cent of drug injection episodes worldwide. Of 70 countries having needle and syringe programmes, only 8 are implementing such programmes in prisons and those that exist tend to be small in scale.

26. Other HIV prevention services that are recommended by the United Nations among people who inject drugs remain limited in their coverage and intensity. In 32 low-income and middle-income countries, only 2.4 per cent of people who inject drugs had access to opioid substitution therapy in 2010. Only an estimated 40 per cent of people who inject drugs used a condom when they last had sex. In countries with epidemics driven in large measure by drug-related transmission, HIV treatment coverage is disproportionately low among people who inject drugs. The same is true for treatment of hepatitis B and C, which is another critical health concern for people who inject drugs.

27. Women who inject drugs are at greatest risk. They are more vulnerable to violence from intimate partners, the police and, if they are sex workers, their clients. HIV-positive women who inject drugs and become pregnant are substantially less likely than other women living with HIV to have access to services to prevent mother-to-child transmission.

28. To make essential harm reduction services available and protect people who inject drugs from HIV infection, countries need to enable legislative and policy frameworks that uphold human rights, avoid punitive approaches such as compulsory treatment and provide support for harm reduction programmes to operate. Several countries, including India, Indonesia, Papua New Guinea and Thailand, have implemented commendable programmes to ensure that law enforcement practices do not impede service access for key populations. The special session of the General Assembly on the world drug problem, to be convened early in 2016, provides an opportunity to link HIV prevention with a broader legal and policy framework pertaining to the use of illicit drugs.

29. International donors account for 92 per cent of all spending on HIV prevention and treatment programmes among people who inject drugs, indicating that few countries have stepped forward to accord priority at the national level to essential health services for this population. Although injecting drug use remains the leading mode of HIV transmission in Eastern Europe and Central Asia, domestic funding

provides only 15 per cent of HIV prevention resources for people who inject drugs in that region.

C. Eliminate new HIV infections in children and substantially reduce AIDS-related maternal deaths

30. One of the greatest recent successes of the global AIDS response has been the turning of the tide against new HIV infections among children. The global community has embarked on an historic undertaking to achieve a 90 per cent reduction in the number of children newly infected between 2009 and 2015, but more focused progress is needed in key countries to reach this target (see table 2).

31. Launched at the high-level meeting on HIV/AIDS, in 2011 the Global Plan Towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive: 2011-2015 calls for four key actions: strengthening primary HIV prevention services for reproductive-age women and their partners; meeting the unmet need for family planning among women living with HIV; providing timely HIV testing, counselling and antiretroviral therapy to pregnant women living with HIV to prevent transmission to their children; and delivering HIV care, treatment and support for women living with HIV, children living with HIV and their families. Developing appropriate systems and structures to provide essential support for HIV-positive pregnant women and their families in all settings is critical to the implementation of this four-pronged approach.

Table 2
Changes between 2009 and 2011 in the number of children (0-14 years of age) acquiring HIV in countries with generalized epidemics

Increase	*Decline of between 1 and 19 per cent*	*Decline of between 20 and 39 per cent*	*Decline of between 40 and 59 per cent*
Angola	Benin	Botswana	Burundi
Congo	Burkina Faso	Cameroon	Kenya
Equatorial Guinea	Central African Republic	Côte d'Ivoire	Namibia
Guinea-Bissau	Chad	Ethiopia	South Africa
	Djibouti	Ghana	Togo
	Eritrea	Guinea	Zambia
	Gabon	Haiti	
	Mozambique	Lesotho	
	Nigeria	Liberia	
	South Sudan	Malawi	
	United Republic of Tanzania	Papua New Guinea	

Increase	*Decline of between 1 and 19 per cent*	*Decline of between 20 and 39 per cent*	*Decline of between 40 and 59 per cent*
		Rwanda	
		Sierra Leone	
		Swaziland	
		Uganda	
		Zimbabwe	

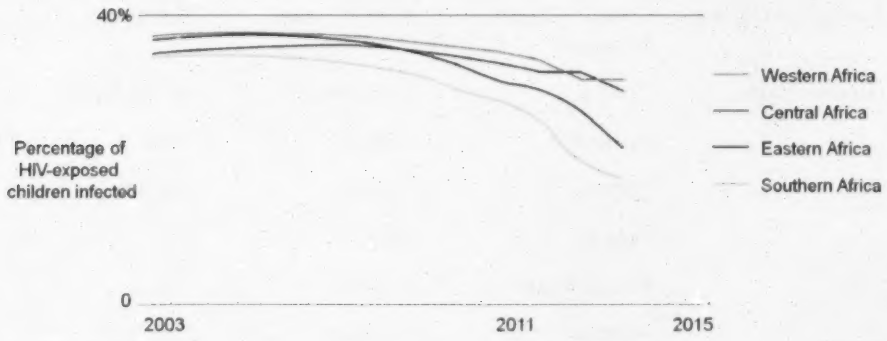
Source: UNAIDS.

Note: As the table uses 2009 as a baseline year, it does not capture significant progress made in many countries (e.g. Botswana) in reducing the number of new infections among children before 2009.

32. Rapid progress has been achieved in scaling up the use of antiretroviral prophylaxis to prevent new HIV infections among children. In 2011, some 57 per cent (51-64 per cent) of pregnant women living with HIV worldwide, and 59 per cent (53-66 per cent) in sub-Saharan Africa, received effective antiretroviral regimens to prevent mother-to-child transmission of HIV. Coverage is substantially lower in South and South-East Asia (18 per cent [13-23 per cent]) and the Middle East and North Africa (7 per cent [6-9 per cent]). There is evidence that the proportion of pairs of women living with HIV and infants provided with prophylaxis during breastfeeding has increased since 2009, although many countries have yet to implement rigorous measures to monitor antiretroviral coverage among breastfeeding women. Programmes to prevent mother-to-child transmission have expanded in humanitarian contexts, but only 39 per cent of operations have achieved 100 per cent coverage (see figure III).

Figure III

Trends in mother-to-child transmission rates by subregion in sub-Saharan Africa, 2000-2011



Source: UNAIDS.

33. Efforts to eliminate new HIV infections among children by 2015 are being impeded by insufficient progress on other priorities of the Global Plan. The number

of new HIV infections remains high among women of reproductive age in the 22 priority countries. With the exception of a few countries, progress in reducing unmet need for family planning has been limited. The transition towards more effective antiretroviral regimens has been far too slow in some settings.

34. Delivering life-preserving treatment to women living with HIV benefits both the women and their children, given that children whose mothers die have an increased risk of death regardless of their own HIV status. Interest is growing in many countries in providing lifelong treatment to HIV-positive pregnant women using a simplified, once-a-day regimen (known as "Option B+").

35. The provision of tuberculosis prevention, screening, treatment and infection control is essential to eliminating new HIV infections among children and keeping mothers alive. Pregnant women living with HIV are 10 times more likely to develop tuberculosis than other pregnant women. Tuberculosis also more than doubles the risk of mother-to-child HIV transmission. In addition, programmes should strengthen the diagnosis of paediatric tuberculosis and increase access to treatment for children in need.

36. It is deplorable that children's access to HIV treatment continues to lag far behind that of adults. Children under 2 years of age living with HIV require immediate access to treatment, but only 28 per cent of children born to HIV-positive pregnant women were screened for HIV within two months of birth in 2010. In 2011, only 28 per cent (25-31 per cent) of children between 0 and 14 years of age who were eligible for antiretroviral therapy under current guidelines were receiving it. To enhance HIV treatment access for children, countries must implement well-designed systems for tracking mother-and-infant pairs and for linking infants to early diagnostic services. Standardization of paediatric antiretroviral formulations is urgently needed.

37. These challenges notwithstanding, recent progress indicates that the goal of eliminating new HIV infections among children and keeping their mothers alive can be attained by 2015. This will require improving programmatic performance, addressing systemic factors that slow progress and stepping up efforts to bring national programmes into line with international recommendations. Programmes for women and children need to respect women's autonomy, build on the involvement and leadership of women living with HIV and take active steps to engage men and boys.

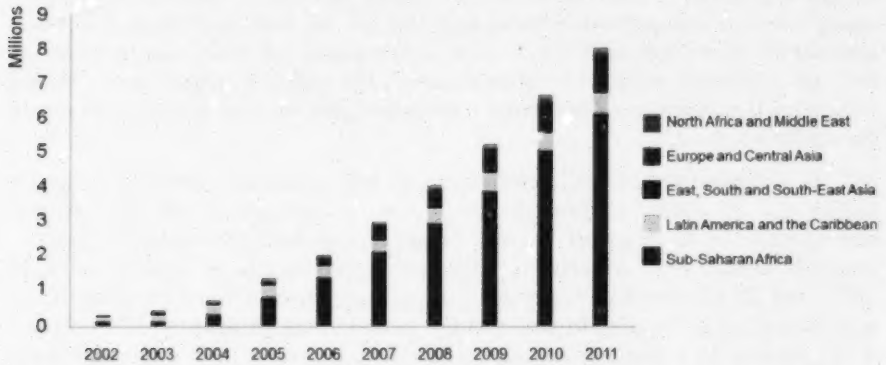
D. Reach 15 million people living with HIV with antiretroviral treatment

38. The expansion of HIV treatment access in low-income and middle-income countries in recent years is one of the most extraordinary achievements in the history of global health. Antiretroviral therapy reduces morbidity and mortality and also prevents new HIV infections. Since 1995, antiretroviral therapy has added 14 million life years in low-income and middle-income countries, including 9 million life years in sub-Saharan Africa.

39. The number of low-income and middle-income countries achieving more than 80 per cent coverage in terms of HIV treatment rose from 7 in 2009 to 10 in 2011, while the number of countries with less than 20 per cent coverage fell from 28 to 10.

The improvements have not been universally shared, however (see figure IV). Persistently below-average treatment coverage in West and Central Africa, Eastern Europe and Central Asia, and the Middle East and North Africa underscores the need to intensify efforts to expand treatment access in regions where coverage lags behind. Men in low-income and middle-income countries have much lower treatment coverage (47 per cent) than women (68 per cent), in part as a result of differences in health-seeking behaviours.

Figure IV
Number of people receiving antiretroviral therapy in low-income and middle-income countries, by region, 2002-2011



Source: UNAIDS.

40. The percentage of adults tested for HIV in the past 12 months is rising, according to surveys carried out between 2004 and 2011 in 14 countries in sub-Saharan Africa. The accelerating uptake of HIV testing and counselling services has been aided by technological and system improvements, including simplified rapid tests, provider-initiated testing in health-care settings, roll-out of home-based testing strategies, decentralization of service delivery, increased integration of HIV testing with other health services and increased use of lay workers to perform rapid tests. Community-based campaigns that focus on education and diagnostic services for multiple diseases have proved effective in expanding access to testing services. These gains notwithstanding, many people continue to be diagnosed late in the course of infection, preventing timely initiation of treatment.

41. As scale-up continues, treatment programmes are becoming more efficient, reducing unit costs, improving health outcomes and enabling limited health budgets to reach more individuals. Simplified drug regimens and the development of point-of-care diagnostic tools have contributed to recent efficiency gains. To ensure that individuals receive the most effective regimens, countries are now working to phase out the antiretroviral drug stavudine owing to its long-term toxicity and side effects.

42. To maximize the health benefits of antiretroviral therapy, gaps throughout the treatment continuum must be closed. Diagnosis must occur early in the course of infection, systems should be in place to link individuals who test positive to immediate medical care, continuing monitoring should ensure timely initiation of therapy and adherence support services should be tailored to individual needs.

Particular efforts are needed to overcome treatment access barriers experienced by adolescents, sex workers, men who have sex with men, transgender people, people who inject drugs, migrants, individuals in humanitarian settings, people in prisons and other closed settings and other groups with diminished access to health care.

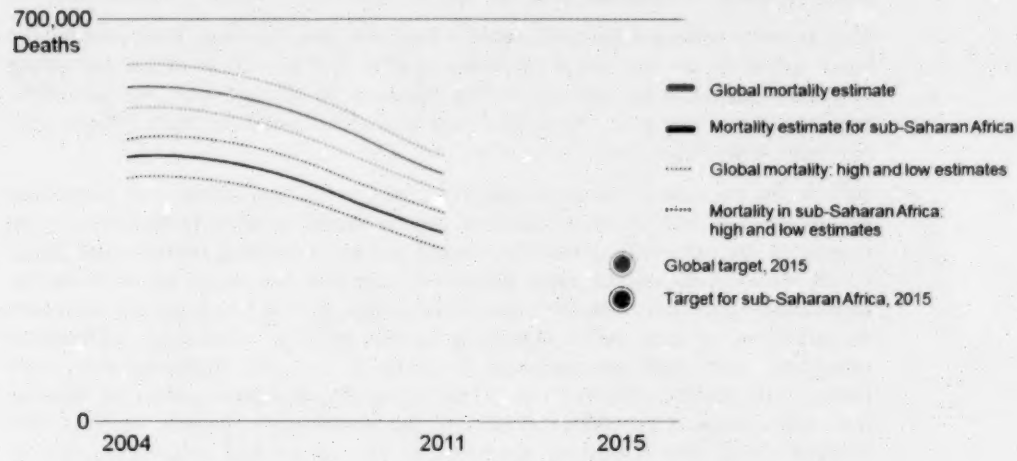
43. In some countries in sub-Saharan Africa, one third or more of all people who begin treatment are no longer receiving it after five years. Countries are testing innovative measures to improve patient retention. In Mozambique, one successful programme saw two-year retention of people in clinic-based treatment programmes rise from 70 to 98 per cent.

44. While the cost of treatment has continued to decline, further cost reductions are essential to accelerate uptake and sustain access to lifelong treatment. Cost reductions are especially critical for second-line and third-line antiretroviral drugs, which remain substantially more expensive than first-line drugs but will become increasingly important in future years as resistance to first-line regimens increases. As countries enhance their capacity to monitor patients' viral load, demand for second-line and third-line regimens is certain to increase. Reducing drug costs further will require effective use of the flexibility available under international intellectual property provisions, preserving the availability of generic alternatives to branded drugs and increasing the capacity of low-income and middle-income countries, in particular in Africa, to develop and manufacture essential medicines. All parties involved in negotiating new free trade agreements should avoid proposing or agreeing to provisions that could diminish the ability of low-income and middle-income countries to obtain a reliable supply of affordable medicines.

E. Reduce tuberculosis deaths among people living with HIV by 50 per cent

45. HIV-associated tuberculosis deaths have fallen, with national implementation of collaborative HIV/tuberculosis activities saving an estimated 1.3 million lives from 2005 to 2011 (see figure V). Tuberculosis remains the leading cause of death for people living with HIV, however, accounting for 1 in 4 such deaths in 2011.

Figure V
Estimated number of tuberculosis-related deaths among people living with HIV, 2004-2011



Source: UNAIDS.

46. Countries have adhered to the recommended approach: intensified case-finding, isoniazid preventive therapy for HIV-positive individuals who do not have active tuberculosis, and effective infection control. HIV treatment scale-up has also led to a decline in HIV-associated tuberculosis mortality, given that antiretroviral therapy significantly reduces the risk of tuberculosis among people living with HIV.

47. Considerable progress has been made in reaching tuberculosis patients with HIV testing services. In 2011, 69 per cent of all people with tuberculosis in sub-Saharan Africa were tested for HIV, although global testing rates were much lower (40 per cent). Among people living with HIV, 3.2 million were screened for tuberculosis in 2011, with 446,000 receiving isoniazid preventive therapy. Experience shows that focused efforts can increase access to essential services. In South Africa, tuberculosis screening among people living with HIV rose nearly twofold in 2011, while the number of people living with HIV receiving preventive tuberculosis therapy increased almost threefold.

48. Early diagnosis of tuberculosis has also played a vital role in reducing tuberculosis-related deaths among people living with HIV. The World Health Organization now recommends a new rapid molecular diagnostic test, Xpert MTB/RIF, to initially diagnose tuberculosis in people living with HIV.

49. It is recommended that all tuberculosis patients living with HIV begin HIV treatment as soon as possible, regardless of their CD4 count. In 2011, however, only 48 per cent of people with both tuberculosis and a documented HIV-positive test result received HIV treatment. In Eastern Europe and Central Asia, where new HIV infections are increasing, a rise in multi-drug-resistant tuberculosis underscores the need to strengthen testing and treatment programmes and to ensure an integrated response to the linked epidemics of HIV and tuberculosis. That many co-infected individuals, including people in prisons and other closed settings, have difficulty

completing prescribed therapy highlights the critical need for adherence support interventions.

50. To accelerate progress, it is essential to ensure women's access to essential tuberculosis services and HIV treatment. In Africa, women are about 20 per cent more likely than men to die of tuberculosis.

51. In March 2013, leaders from the Southern African Development Community joined global partners to launch an initiative for accelerated action on tuberculosis and HIV in the coming 1,000 days (i.e. until the deadline for the attainment of the Millennium Development Goals). UNAIDS called for zero tolerance of parallel systems for delivery of tuberculosis and HIV services. To rapidly reduce the number of tuberculosis deaths among people living with HIV, tuberculosis and HIV services should be integrated, where possible, and provided at the same site to ensure patient-centred services. HIV treatment should be scaled up using decentralized service networks. Food, nutrition support and other interventions shown to improve tuberculosis outcomes should be integrated into programmes for people with tuberculosis/HIV co-infections. Collaborative tuberculosis/HIV activities should also be integrated into services such as maternal and child health programmes, programmes to prevent mother-to-child HIV transmission, harm reduction and drug treatment programmes and prison health services.

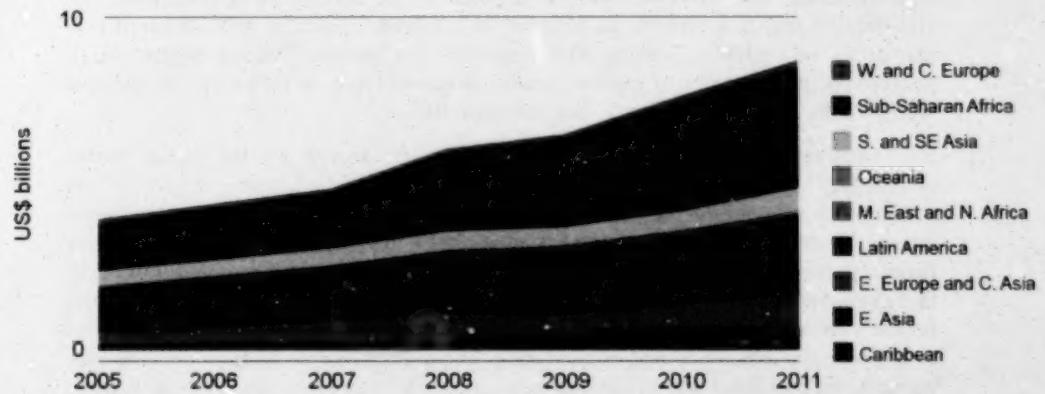
F. Close the global AIDS resource gap

52. Total annual resources of between $22 billion and $24 billion will be needed by 2015 to help to lay the foundations for an end to the epidemic. UNAIDS recommends that all partners pursue an investment approach, focusing funding on high-impact strategies that respond to documented needs.

Figure VI

Domestic public and private resources available for HIV in low-income and middle-income countries, 2005-2011

(Billions of current United States dollars)



Source: UNAIDS.

53. In 2011, $16.8 billion was invested in HIV-related activities worldwide — more than $5 billion short of the minimum that will be needed in 2015. For the first time, low-income and middle-income countries accounted for the majority of HIV expenditures in 2011, contributing $8.6 billion — more than double their investment in 2005 (see figure VI). There is substantial room for progress, however, given that most African countries have yet to reach the target of the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases of allocating at least 15 per cent of their national budget to health programmes. Taking projected economic growth into account, UNAIDS projects that African countries alone could mobilize an additional $5 billion for the AIDS response by 2015 by achieving that target and by bringing national HIV investment into line with the proportion of the national health burden caused by the epidemic.

54. The increase in domestic investment notwithstanding, international donors must continue to play a pivotal role in financing the response. A total of 23 States members of the Organization for Economic Cooperation and Development increased their HIV-related disbursements by 10 per cent in 2011. In 2012, the President's Emergency Plan for AIDS Relief, launched by the President of the United States in 2003, released a blueprint for strategic action to achieve progress towards an AIDS-free generation. In 2013, the Global Fund to Fight AIDS, Tuberculosis and Malaria launched a new funding model that will accord priority to assistance to the most heavily affected countries and focus funding on interventions that will have the greatest health impact.

55. In 2012, UNAIDS worked with 49 countries to assess national HIV spending, with the aim of bringing spending patterns into line with investment principles. Cambodia, for example, has embarked on a new approach known as "Cambodia 3.0", which seeks to do more and better with less by boosting priority interventions, adopting innovative strategies (such as community-based service delivery) to increase programmatic reach and effectiveness and using strategic information to improve the quality, efficiency and effectiveness of interventions.

56. Inequities in financing must be addressed while intensifying resource mobilization efforts. Programmes for key populations at higher risk remain badly underfinanced and overwhelmingly dependent on international financing. Of HIV-related spending specific to women, 71 per cent focuses on prevention of new infections in children, leaving few resources for women-focused primary HIV prevention, programmes to prevent gender-based violence or initiatives to alleviate women's disproportionate caregiving responsibilities.

57. Closing the resource gap is a responsibility shared by the entire global community. To close the gap, low-income and middle-income countries are encouraged to continue to increase their domestic investment and international donors to maintain their commitment to global solidarity. In addition, innovative financing mechanisms should be aggressively pursued. A critical moment will occur in September 2013, when public and private donors convene to replenish funding for the Global Fund for the period 2014-2016. In addition, greater efforts are needed to improve the efficiency and effectiveness of programmes; to address demand-side barriers, such as food and livelihood insecurity, which prevent people from gaining access and adhering to health services; and to rationalize and eliminate parallel administrative and reporting systems.

G. Meet the specific needs of women and girls and eliminate gender inequalities and gender-based abuse and violence

58. Inequitable gender norms exacerbate women's vulnerability by limiting their access to education and employment, undermining their capacity to reduce their risk of sexual HIV transmission and exposing them to the risk of violence or social ostracism. Women are also placed at higher risk of HIV infection through sexual partnerships with men who have sex with men, people who inject drugs or sex work clients. One study estimates that 50 million women in Asia are at risk of becoming infected by their intimate partners. Gender norms also harm men, encouraging high-risk behaviour and deterring them from seeking essential health services. Prevailing gender norms also increase the vulnerability of transgender people and impede their access to HIV services and safe and secure livelihoods.

59. Consistent with the Five-Year Action Agenda of the Secretary-General, the Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV launched by UNAIDS calls for focused efforts to help countries to address the needs and rights of women and girls in the context of HIV. It has fostered political commitment and accelerated action, with 60 per cent of countries having used it to strengthen gender equality within AIDS responses.

60. Regrettably, insufficient attention is being paid to gender inequality and its impact on women's HIV-related needs. In 2011, only one third of countries had brought female condom programming to scale, only one third reported having integrated HIV and sexual and reproductive health services and only 1 in 10 effectively engaged men and boys in response efforts.

61. Prevalence of intimate-partner violence in the past 12 months ranges from 5 per cent to 69 per cent among countries surveyed. Together for Girls is an international coalition of United Nations agencies and government and private-sector partners working to support national surveys, evidence-based action, global advocacy and public awareness to tackle the epidemic of sexual violence against women and girls.

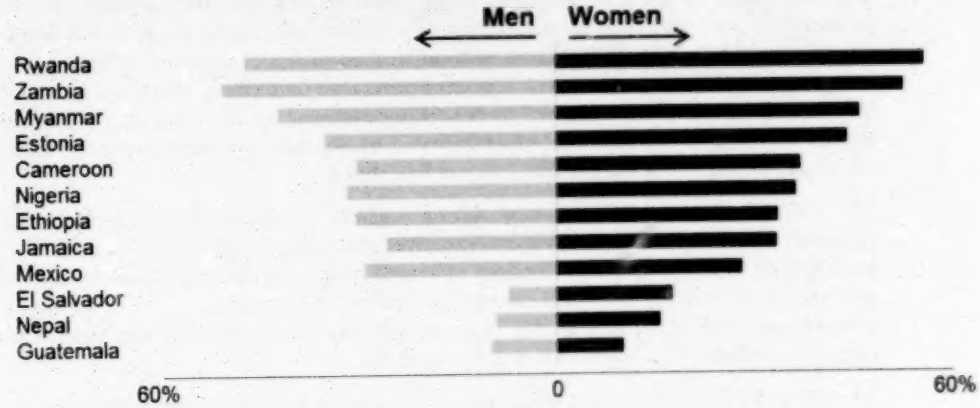
H. Eliminate stigma and discrimination against people living with and affected by HIV

62. More than three decades after cases of AIDS were first reported, stigma and discrimination against people living with or affected by HIV continue to undermine an effective response. Data collected through the People Living with HIV Stigma Index indicate that large percentages of people living with HIV have experienced physical or verbal abuse, social ostracism and emotional distress. According to studies in nine countries, the percentage of people living with HIV who reported experiencing discrimination in the workplace ranged from 8 per cent in Estonia to 54 per cent in Malaysia.

63. Women living with HIV often experience higher levels of stigma and discrimination. Men and women living with HIV experience verbal violence (see figure VII) and physical violence (see figure VIII), with women suffering more. According to national surveys, women are more likely than their male counterparts to be verbally insulted or physically assaulted, to lose employment and to feel

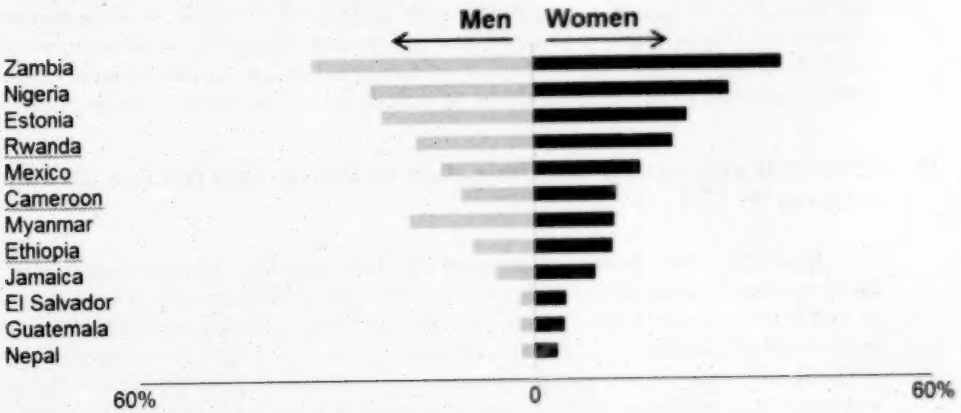
shame. Involuntary sterilization of women living with HIV has been reported in numerous countries.

Figure VII
Percentage of men and women living with HIV experiencing verbal violence in countries with available sex-disaggregated data



Source: UNAIDS.

Figure VIII
Percentage of men and women living with HIV experiencing physical violence in countries with available sex-disaggregated data



Source: UNAIDS.

64. The Five-Year Action Agenda calls for a policy framework that protects against human rights violations and advances a responsibility to protect populations. Too few countries have implemented HIV policy frameworks that support a human rights approach. In 2012, 4 in 10 countries reported having no specific legal provisions to prevent or address HIV-related discrimination. The proportion of countries having HIV-related legal services in place rose from 45 per cent in 2008 to 55 per cent in 2012, but many countries have failed to take steps to enforce those rights.

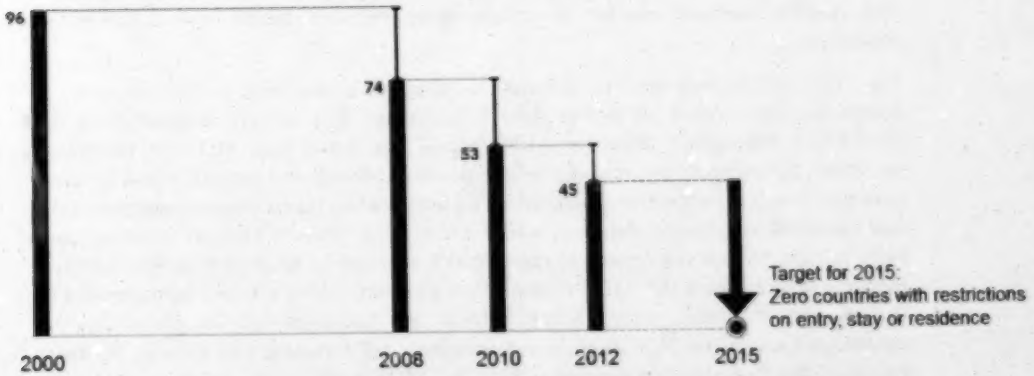
65. At least 60 per cent of countries reported laws, regulations and policies that present obstacles to effective prevention, treatment, care and support. In addition, 43 per cent of countries with refugees have no legislation protecting the rights of asylum seekers living with HIV. Some 60 countries have adopted laws specifically criminalizing HIV transmission, more than 40 per cent of countries have criminalized same-sex relations and most countries have laws deeming some aspect of sex work to be illegal. According to an international review, punitive approaches to drug use, including criminalization of individuals who are dependent on drugs, maintaining compulsory detention centres for people who use drugs or prohibitions of programmatic components of harm reduction, are widespread and undermine access to HIV services.

66. The Global Commission on HIV and the Law has recommended that countries explicitly prohibit HIV-related discrimination; avoid criminalizing HIV exposure, non-disclosure or transmission; enact specific protection for women and girls; use legal measures to ensure treatment access; and remove punitive or discriminatory laws and policies regarding key populations and vulnerable groups. All partners must strengthen efforts to ensure the implementation of those recommendations, which are critical to managing, controlling and eliminating the spread of HIV.

I. Eliminate HIV-related restrictions on entry, stay and residence

67. There is a clear international trend away from HIV-related restrictions on entry, stay and residence, with the overwhelming majority of countries and territories having rejected such discriminatory measures (see figure IX). From 2000 to 2012, the number of countries, territories and areas with HIV-related travel restrictions fell by more than half, from 96 to 45. Since 2010, nine countries (Armenia, China, Fiji, Mongolia, Namibia, the Republic of Korea, the Republic of Moldova, Ukraine and the United States) have abolished their national restrictions.

Figure IX
Number of countries with restrictions on entry, stay and residence for people living with HIV, 2000-2012 and 2015 target



Source: UNAIDS.

68. Restrictions on entry, stay and residence cannot be justified by public health considerations, yet such measures persist and continue to impose severe burdens on people living with HIV and their households. Five countries maintain a blanket ban on entry by people living with HIV. Another five require proof of HIV-negative status for individuals wishing to stay for short periods (10-90 days). Twenty authorize the deportation of HIV-positive people.

69. In addition to the direct harm caused to people living with HIV, there is also growing recognition of the economic costs of travel restrictions in an era in which businesses need the ability to send human resources — as with capital and commodities resources — to where they are most needed. In 2012, some 40 corporate chief executives, representing nearly 2 million employees worldwide, called for all HIV-related restrictions on entry, stay and residence to be abolished.

J. Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response

70. In the 2011 Political Declaration on HIV and AIDS, a call was made for concerted efforts to link the AIDS response more closely with the broader development and human rights agenda. The emphasis on an integrated response recognizes the many ways in which halting and reversing the epidemic depends on progress across the array of Millennium Development Goals and the broader development agenda, in addition to the ways in which progress on AIDS advances progress towards other global health aims. An approach that integrally links HIV and other health and development efforts also supports sustainability, in keeping with the Five-Year Action Agenda.

71. The world has much to learn from the response to AIDS. The remarkable results achieved to date demonstrate the power of a people-centred response. The AIDS response has pioneered innovative approaches to global health governance through principles of inclusion, accountability, shared responsibility and global solidarity. By building on that progress to establish a strong foundation for the eventual end of AIDS, it is possible to show the world what can be achieved through empowered and mobilized communities and a unified international effort. Success will inspire renewed resolve to tackle other difficult health and development challenges.

72. The AIDS response is helping to strengthen national health systems. A comprehensive review of health data in countries that receive support from the President's Emergency Plan for AIDS Relief has found that AIDS programming increases life expectancy, reduces tuberculosis incidence and mortality and bolsters national health infrastructure. Numerous countries have taken steps to integrate HIV and tuberculosis service delivery, while services to prevent HIV in children have been integrated into maternal and child health services in all high-burden countries. Lessons learned from the AIDS response are now informing clinical management of diabetes in Ethiopia, while South Africa has launched an integrated testing campaign focused on HIV, high blood pressure and diabetes. The George W. Bush Institute, the President's Emergency Plan for AIDS Relief, Susan G. Komen for the Cure and UNAIDS have jointly launched a new initiative to expand HIV, cervical and breast cancer screening and treatment for women in sub-Saharan Africa and Latin America.

73. HIV-focused interventions are being integrated into broader social protection systems. According to a recent study by the World Bank, some types of social protection investment addressing the economic and social vulnerabilities of those in greatest need are effectively reaching households with orphans and vulnerable children and high rates of dependence.

74. HIV has also been broadly integrated into humanitarian operations. In 2012, a multidisciplinary group of experts issued guidance to inform research and practice with regard to the alignment of HIV prevention services and gender-based violence in conflict and post-conflict settings.

75. Concerted efforts are needed to seize additional opportunities for integration. HIV services must be integrated more comprehensively into sexual and reproductive health services. The HIV context needs to be taken into account in policies and programmes to prevent gender-based violence. HIV-specific clinical services must also be linked with efforts to address non-communicable diseases, given that such diseases are on the rise in low-income and middle-income countries. The AIDS response can also inform and benefit from the international push towards universal health coverage.

IV. Focusing on accountability for results: accelerating progress towards the 2015 targets

76. With the 2015 deadline for the global targets rapidly approaching, all stakeholders must renew their focus on accountability for results. To accelerate progress and increase accountability and transparency, the UNAIDS reports on the global AIDS epidemic will be published every year rather than every two years from 2013. Annual reporting will allow more timely assessment of progress and shortcomings and underscore the urgency of immediate action to achieve results.

77. Leaders and communities worldwide have embraced their own accountability in the response efforts. Citing the 2015 targets in the 2011 Political Declaration on HIV and AIDS, the health ministers of the Association of Southeast Asian Nations joined together in 2012 to pledge focused and specialized action throughout the region to reduce HIV among women and girls.

78. The African Union road map on shared responsibility and global solidarity for AIDS, tuberculosis and malaria response in Africa reflects the commitment and determination of African leaders to make strategic investment in a sustainable response that delivers results. It has three key pillars: more diversified, balanced and sustainable financing models; access to medicines, including through local production and regulatory harmonization; and leadership, governance and oversight for sustainability.

79. To achieve the 2015 targets, the research advances of recent years will need to be translated into effective programmes. It is essential to avoid the historic lag between the emergence of new health tools and their effective introduction in resource-limited settings. With the knowledge base on HIV rapidly evolving, programme planners and implementers will need to remain abreast of research developments and adapt their approaches as new learning becomes available. Strategic information needs to be used more effectively to focus programmes where they are most needed. A greater commitment to timely programme monitoring is

also critical so as to enable programmes to build on successes and address bottlenecks as they emerge.

80. Renewed commitment and solidarity is essential if the 2015 targets are to be attained. The gains of recent years should be used as inspiration to see this process through to the end and not as an excuse to diminish global commitment to one of the most serious health challenges of human times. AIDS is not over. Indeed, the epidemic continues to expand in many parts of the world. As an unfinished Millennium Development Goal, the AIDS response must have a prominent place in the post-2015 development agenda. Towards this end, UNAIDS and *The Lancet* have established a new commission, From AIDS to Sustainable Health.

V. Conclusions and recommendations

81. To seize the historic opportunity to lay the groundwork for an AIDS-free generation, the following recommendations require immediate implementation:

(a) **Specific steps should be taken immediately to close the AIDS resource gap**. Low-income and middle-income countries, international donors, United Nations agencies, civil society and other partners should join together in a common effort to mobilize financing of at least $22 billion-$24 billion annually for HIV-related activities. Emulating the actions of China, South Africa and other countries that have increased domestic investment, all low-income and middle-income countries should reassess national spending priorities. International donors should sustain and increase their investment in HIV-related programmes, with high-income countries whose contributions do not match their share of the global economy making particular efforts. Urgent attention is needed to ensure the robust replenishment of the Global Fund, which will remain a critical funding source for the AIDS response in future years;

(b) **Allocation of scarce AIDS resources must become more strategic**. With the assistance of technical partners, all countries should assess and revise investment priorities to maximize impact and promote a sustainable response. Focused resources should accelerate the scaling-up of basic programmatic activities. Such activities should be complemented by strategic investment in critical enabling policies and programmes to build demand and minimize disincentives for services, as well as by synergistic development interventions that reduce vulnerability and mitigate the social and economic impact of AIDS on vulnerable families (e.g. social protection and education);

(c) **With the support of technical partners, all countries should undertake strategic exercises to identify and capture synergies within their health and social protection systems**. HIV and tuberculosis services must be fully integrated; services to eliminate mother-to-child transmission must be further integrated into antenatal service delivery; services should be closely linked with sexual and reproductive health services; and HIV should be integrated with, and inform, the delivery of treatment, care and support for non-communicable diseases. All countries should strive towards universal health coverage, ensuring that the needs of people living with HIV are addressed. Intensified action is also needed to scale up cash transfer and other social protection programmes, in particular for children orphaned and made vulnerable by HIV, given that, without the socialization,

education and nurturing that parents provide, children may fall through the cracks, putting them at further risk of exposure to HIV;

(d) **All stakeholders should work together to eliminate inequities in access to HIV-related services**. Focused resources are needed to address the HIV-related needs of women above and beyond current programmes and to eliminate new infections among children. Urgent efforts are also needed to reach men with testing, counselling, treatment and care. As a component of the strategic reassessment of HIV-related investment, countries should increase the resources available for evidence-informed, rights-based programmes to address the needs of men who have sex with men, people who inject drugs, sex workers and their clients, and other vulnerable populations, including their intimate partners. Countries should review their legal and policy frameworks to remove punitive laws and other measures that impede access to essential services and to ensure that specific measures are in place to prohibit discrimination and guarantee access to legal services for key populations and people living with HIV;

(e) **New people-centred approaches to the cultivation and mobilization of leadership are needed. Emerging regional leadership on AIDS must be supported and encouraged, with a particular focus on regional efforts to promote greater accountability in the response**. Emerging economies should step forward to help to lead the global response. Powerful new communications and mobilization tools, such as social media, should be leveraged to reach current and future generations of young people;

(f) **The post-2015 international development agenda should take forward the vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths**. AIDS will remain a major global challenge well beyond 2015. The post-2015 international development agenda should clearly reflect the role of an effective AIDS response as an essential pillar of future health and development efforts.

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Prevention of armed conflict

Protracted conflicts in the GUAM area and their implications for international peace, security and development

Security Council
Sixty-eighth year

Letter dated 3 April 2013 from the Permanent Representative of Armenia to the United Nations addressed to the Secretary-General

Upon instructions from my Government, I draw your attention to the ongoing violations of the ceasefire by the armed forces of the Republic of Azerbaijan recorded for the month of March 2013 (see annex).

I should be grateful if you would circulate the present letter and its annex as a document of the General Assembly, under agenda items 33 and 34, and of the Security Council.

(*Signed*) Garen **Nazarian**
Ambassador
Permanent Representative

13-28258 (E) 100413

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Annex to the letter dated 3 April 2013 from the Permanent Representative of Armenia to the United Nations addressed to the Secretary-General

Violations of the ceasefire by the armed forces of the Republic of Azerbaijan, 1-31 March 2013

1. On the borderline of the Nagorno Karabakh Republic:

   Total number of violations — 1,364

   Total number of shots ~ 5,443

   AK ~ 3,945, PK ~ 768, SVD ~ 418, DSHK ~ 87, RPK ~ 33, Black Arrow ~ 73, Istiglal ~ 69, Utyos ~ 20, NSVP ~ 30

2. On the borderline of the Republic of Armenia (see table below):

   Total number of violations — 119

   Total number of shots ~ 1,000

   AK ~ 429, PK ~ 334, SVD ~ 170, DSHK ~ 36, RPK ~ 6, Black Arrow ~ 25

No.	*Date*	*Direction*	*Time*	*Type of weapon*	*Ammunition*
1.	1 March	Chinari	0120	RPK	2
2.		Sarigyugh	0710	SVD	3
3.		Paravaqar	1030	AK	2
4.		Aygepar	2100		1
5.			2225		1
6.	2 March	N. Karmiraghbyur	0055	AK	15
7.		Aygepar	0620		1
8.			2320		1
9.	3 March	Movses	1735	AK	1
10.		Aygepar			2
11.	4 March	Aygepar	2030	AK	1
12.		Vazashen	2245		10
13.	5 March	Berqaber	2320	PK	5

Abbreviations: PK, Kalashnikov machine gun; SVD, 7.9-mm sniper weapon; AK, Kalashnikov rifle; DSHK, 12.7-mm machine gun; RPK, 5.45-mm machine gun; Istiglal, 14.5-mm machine gun; Black Arrow, 12.7-mm sniper weapon; Utyos, 12.7-mm machine gun; NSVP, 12.7-mm machine gun.

No.	*Date*	*Direction*	*Time*	*Type of weapon*	*Ammunition*
14.	6 March	Chinari	0025	SVD	3
15.		Berqaber	0100	AK	2
16.				SVD	2
17.				PK	33
18.		N. Karmiraghbyur	0154	AK	2
19.		Movses	1250	SVD	9
20.	8 March	Vazashen	0140	AK	15
21.		Chinari	1420	PK	5
22.				SVD	15
23.				AK	5
24.		Aygepar	1530	PK	1
25.	10 March	Tiu Jur	1155	AK	8
26.		Chinari	1615	SVD	2
27.			2315		3
28.	11 March	N. Karmiraghbyur	1015	AK	5
29.		Aygepar	2315		1
30.	12 March	Vazashen	1230	AK	5
31.		Movses	1300		10
32.		Aygepar	1320	SVD	1
33.		Chinari	2115	PK	5
34.	13 March	Chinari	2140	SVD	18
35.				PK	10
36.				AK	45
37.	14 March	Aygepar	1245	AK	1
38.		Movses	1400		10
39.		Berqaber	1615		4
40.		Barekamavan	1730		22
41.		Dovegh	1730	SVD	6
42.		Berdavan	1745	AK	50

No.	*Date*	*Direction*	*Time*	*Type of weapon*	*Ammunition*
43.		Sevakavan	2000		20
44.	15 March	Paravaqar	1040	AK	4
45.			2205		3
46.		Movses	1630	PK	4
47.			1705	AK	7
48.			1850		10
49.		Vazashen	1630	SVD	35
50.		Chinari	1835	PK	30
51.			1850		50
52.				DSHK	20
53.			1920	PK	20
54.		Berdavan	2300	AK	5
55.	16 March	Koti	0125	AK	4
56.		Chinari	1700	SVD	3
57.				PK	5
58.	17 March	Aygehovit	1640	AK	12
59.			1700	PK	5
60.				AK	4
61.		Eraskh	1930	AK	3
62.		Berdavan	2140		15
63.	18 March	Barcruni	2015	RPK	4
64.		Tigranashen	2045	AK	5
65.	19 March	Agarak	1255	AK	1
66.			2320		2
67.		Vazashen	1820	PK	6
68.			2240	AK	10
69.		Chinari	1830	SVD	9
70.			2330	AK	3
71.	20 March	Berdavan	1815	Black Arrow	2

No.	*Date*	*Direction*	*Time*	*Type of weapon*	*Ammunition*
72.		Vazashen	2135	PK	45
73.		Chinari	2210	SVD	1
74.	21 March	Eraskh	0215	AK	3
75.		Arcvaberd	1200	Black Arrow	10
76.		Kiranc	2030	SVD	4
77.		Vazashen	2105		10
78.			2245	PK	7
79.			2315	SVD	20
80.				PK	40
81.		Aygepar	2110	AK	3
82.	22 March	Paravaqar	2005	Black Arrow	5
83.		Sevakavan	2320	AK	4
84.	23 March	N. Karmiraghbyur	1310	AK	3
85.	24 March	Chinari	0005	SVD	1
86.			1150	AK	6
87.			2120	PK	2
88.		Aygepar	2100	AK	1
89.	25 March	Chinari	0215	SVD	1
90.			1550		2
91.			2320	AK	1
92.		Barekamavan	1740	SVD	2
93.		Vazashen	2316	PK	50
94.	26 March		1135	SVD	2
95.		Aygedzor	2130	AK	1
96.			2320		1
97.	27 March	Chinari	0010	SVD	1
98.			2330	DSHK	6
99.		Vazashen	0020	PK	7
100.		Paravaqar	2020	AK	7

No.	*Date*	*Direction*	*Time*	*Type of weapon*	*Ammunition*
101.	28 March	Berqaber	0100	AK	4
102.		Paravaqar	1410		5
103.		Chinari	2000	SVD	1
104.				AK	8
105.		Mehrab	2125		3
106.	29 March	Chinari	1145	Black Arrow	1
107.		Aygedzor	1310	AK	6
108.				SVD	1
109.	30 March	Aygepar	0940	AK	5
110.	31 March	Movses	0030	AK	4
111.		Vazashen	1000		1
112.		Aygepar	1045		2
113.			1050		3
114.		Chinari	1320	Black Arrow	7
115.			1755	DSHK	10
116.			1800	AK	30
117.				SVD	15
118.			1900	PK	2
119.			2040		2